BOARD OF PROFESSIONAL COUNSELORS OF MENTAL HEALTH and
LICENSED CHEMICAL DEPENDENCY PROFESSIONALS

DIRECT SUPERVISION REFERENCE FORM
(To be completed by Direct Supervisor)

1. Name of Applicant: _____

2. Name of Direct Supervisor: _____

   Title: _____ Phone: (_____) _____-_____

   Setting/Location Name: _____

   Address: _____

   _____ Zip Code: _____

2. Dates of Direct Supervision: From _____ to _____

   Total Number of Hours of Direct Supervision: _____*

   Number of Hours of Individual Face-to-Face Supervision: _____

   Number of Hours of Group Face-to-Face Supervision: _____

   Total Number of Hours of Face-to-Face Supervision: _____

3. Did you provide the actual face-to-face supervision of this applicant?

   Yes _____ No _____ If not, who did? _____

4. Where did this supervision occur? _____

   _____

5. Please list the mental-health-related license(s) you held at the time of this supervision:

State	Type of License	License Number	Date Licensed

*Minimum 1,600 hours of directly supervised experience, at least 100 hours of which shall consist of face-to-face supervision.

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I certify that the information provided herein is accurate and complete to the best of my knowledge and belief and that this applicant competently and satisfactorily performed his/her counseling duties.

____ ____________________

Signature of Clinical Supervisor Date